NOTICE OF INDEPENDENT REVIEW DECISION

August 28, 2002

RE: MDR Tracking #: M2-02-0891-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 47 year old male sustained a work related injury on ___ when he fell thirteen feet from a platform onto his feet and buttock. An MRI performed on 09/25/01 revealed degenerative disease at L4-5 and L5-S1. A lumbar CT scan revealed diffuse degenerative tears at L4-5 and L5-S1 and some posterior annular tears at L2-3. The treating physician is recommending that the patient undergo a selective endoscopic discectomy.

Requested Service(s)

Endoscopic discectomy

Decision

It is determined that an endoscopic discectomy is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

A discectomy is not the appropriate procedure to treat this patient with axial pain syndrome in the lumbar spine. The medical record documentation fails to indicate that the patient received conservative treatment in the form of steroid injections into the disc spaces and epidural spaces prior to the consideration of surgical intervention. Therefore, the endoscopic discectomy is not medically appropriate treatment.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,